E. QUALIFICATION OF PROVIDERS

Providers of case management services to recipients who are participating in Community Care Organizations (CCO's) must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group B:

Recipients of early periodic screening, diagnosis and testing services (HealthCheck).

B. Areas of State in which services will be provided:

Eff. 4-1-93

[X] Entire State.

See narrative B. in the following section for Target Group C, page 1-C-1.

Currently, this benefit is available statewide, but provider participation is voluntary.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide).

C. Comparability of Services:

[X] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[ ] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case Management Services are defined as including the following activities for targeted recipients: pro-active outreach to get non-users into a screening, a comprehensive health and social service assessment, referral to resources beyond the EPSDT screening process, health and MA utilization education, removal of barriers to accessing service resources (both EPSDT related, and non-covered), follow-up and linkage of the recipient to a primary care physician and dentist (as appropriate) for future care.

E. Qualification of Providers:

Medicaid-certified providers of EPSDT health assessment and evaluation services shall be eligible to receive reimbursement for EPSDT case management in accordance with the limitations contained in the case management agreement between the provider and the department.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group C:

Recipients who are age 65 or older. See attached.

B. Areas of State in which services will be provided:

☐ Entire State.

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

The benefit is available statewide, but provider participation will be voluntary. It is assumed that initial participation of providers will see a majority of counties covered, and most target populations selected. The State will require the county board of supervisors in any county in which the benefit is provided, to elect to have this benefit offered. This will ensure coordination and enhance case management.

Eff. 4-1-93 All but the following counties have indicated that they provide case management services for persons in this target group: Adams, Douglas, Florence, Jefferson, Vernon and Washington.

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached.

E. Qualification of Providers:

See attached.

F. The State assures that the provision of case management services will not restrict an individual's freedom of choice with regard to providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of other health care providers under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

A. TARGET GROUP:

Targeted Group: This target group consists of persons who are:

1. At least 65 years old or older and who are:

   a. Medically eligible for Medical Assistance (MA);

   b. Recipients with a long-term chronic or irreversible illness or disability resulting in significant functional impairment;

   c. Documented as having multiple, complex, and diverse service needs and an inability or lack of a support system to meet those needs without the availability of case management;

   d. Residing in their own homes, the home of another or in a community home.

D. DEFINITION OF MEDICAID - COVERED CASE MANAGEMENT SERVICES

Case management services are those services and activities which help MA recipients, and when appropriate, their families, to identify their needs, and manage and gain access to necessary medical, social, rehabilitation, vocational, educational, and other services.

Basic Assumptions

There are some basic assumptions upon which MA coverage of case management (CM) is based.

First, CM is viewed as an instrument used by CM providers to effectively manage multiple resources for and to gain access and have linkages with needed services for the benefit of MA-eligible persons who belong to the targeted group(s).

Effective management is concerned with the adequacy, quality and continuity of CM services. Gaining access to and having linkages with needed services is concerned with the availability of services, the identification of appropriate service providers, and the determination that case management providers and other service providers can and will serve recipients. In order to further ensure the effectiveness of case management, ongoing monitoring and service coordination will be done by one case manager. This furthers consistency with regard to the delivery of CM services and affords a single contact point for the recipient.

Targeted groups consist of functionally and/or developmentally limited persons with multiple needs and/or high vulnerability who require intensive and/or ongoing intervention by health, social, and other human services providers.

Second, recipients will voluntarily participate in CM services by maintaining contact with and receiving services from case management provider(s). MA recipients will be free to choose CM services when they become aware of those services and those case management providers available to them. The State of Wisconsin is prepared to assure a recipient's knowledge and freedom of choice of provider by informing recipients through a Recipient Handbook and through MA Recipient written and telephone services. Furthermore, freedom of choice is guaranteed through service monitoring and the establishment of a complaint and investigating capacity in the Department of Health and Social Services' (DHSS) Bureau of Long Term Support. This will be in addition to the normal appeal rights to which any recipient is entitled. Recipients and their families shall participate, to the fullest extent of their ability, in all decisions regarding appropriate services and case management providers.

Even though MA is funding CM services as an enhancement of Medicaid funding and as an extension of traditional Medicaid services, the State will focus on appropriate CM practices as they relate to human services needs as well as the more specialized Medicaid requirements.

Core Elements of Case Management

MA reimbursement will be available only to CM providers with qualified staff, the capability of delivering all of the following elements of CM, and who are certified by the DHSS. It should be noted that not all recipients assessed will actually need case management. As a result of the assessment, it may be determined that further CM service components are not appropriate or necessary for a recipient. However, each case management provider must make all of the following elements available for all assessed persons who are determined to need CM services.

1. Assessment - A CM provider must have the capacity and ability to perform a written comprehensive assessment of a person's abilities, deficits, and needs. Persons from relevant disciplines should be used to document service gaps and unmet needs. All services appropriate to the recipient's needs should be part of this activity. The following areas must be documented and addressed when relevant:

a. Identifying information (referral source, emergency contacts, source of assessment information, etc.);

b. Physical and/or dental health assessments and consideration of potential for rehabilitation (health problems/concerns, current diagnoses, medications, treatments, physical and/or sensory impairments, etc.);

c. Review of the recipient's performance in carrying out activities of daily living (such as mobility levels, personal care, household chores, personal business, and the amount of assistance required);

d. Social interactive skills and activities (behavior problems or concerns, alcohol/drug abuse, etc.);

e. Record of psychiatric symptomology and mental and emotional status (intellectual functioning, mental impairments, alcohol/drug abuse, etc.);

f. Identification of social relationships and support (informal care givers, i.e., family, friends, volunteers, formal service providers, significant issues in relationships, social environment);

g. Description of the recipient's physical environment (safety and mobility in home and accessibility);

h. In-depth financial resource analysis and planning, (including identification of and coordination with insurance and veteran's benefits, and other sources of financial assistance);

i. Recipient's need for housing, residential support, adaptive equipment (and assistance with decision-making in these areas);

j. Vocational and educational status and daily structure (prognosis for employment, educational/vocational needs, appropriateness/availability of educational programs);

k. Legal status, if appropriate (guardian relationships, involvement with the legal system);

l. Accessibility to community resources needed or wanted by the recipient.

m. For a recipient identified as severely emotionally disturbed under age 21, a record of the multidisciplinary team evaluation required under state law.

n. Assessment of drug and/or alcohol use and misuse for recipients identified as alcoholic or drug dependent.

Assessments must be done by a person or persons from a discipline that matches the needs and/or dysfunctions identified in the specific target population in which the recipient is included. Persons from other disciplines will be included when results of the assessment are interpreted. Using the assessment to document service gaps and unmet needs enables the CM provider to act as an advocate for the recipient and to assist other human service providers in planning and program development on the recipient's behalf.

Should the assessment reveal that the recipient does not need CM services, appropriate referrals should be made to meet other client needs.

2. Case Plan Development - Following the assessment and determination of the need for case management, the case management provider develops a written plan of care, called the case plan, as a vehicle to address the needs of the recipient, enabling him/her to live in the community. To the maximum extent possible, the development of a case plan is a collaborative process involving the recipient, the family or other support systems and the case management provider. It is a negotiated agreement on the short- and long-term goals of care and includes at a minimum:

a. Problems identified during the assessment;

b. Goals to be achieved;

c. Identification of all formal services to be arranged for the recipient, including costs and the names of the service providers;

d. Development of a support system, including a description of the recipient's informal support system;

e. Identification of individuals who participated in development of the plan of care;

f. Schedules of initiation and frequency of the various services to be made available to the recipient, and

g. Documentation of unmet needs and gaps in service(s).

Services for every case management recipient must be guided by a written case plan.

3. Ongoing Monitoring and Service Coordination - The CM provider ascertains, on an ongoing basis, what services have been or are being delivered to a recipient, and whether they are adequate for the recipient's needs. A single case manager will be assigned to the recipient to provide supportive contact to ensure that the person is able to access services, is actually receiving services, or is engaging in activities specified in the recipient's case plan. Client and family satisfaction and participation is also monitored. The case manager will identify any changes in the client's condition that would require an adjustment in the case plan or arrangements for other services. This monitoring function does not preclude independent monitoring for purposes of evaluation of MA quality assurance.

Ongoing monitoring and service coordination includes:

a. Face-to-face and telephone contacts with recipients (who are not hospital inpatient or nursing home residents) for the purpose of assessing or reassessing needs, or planning or monitoring services;

b. Face-to-face and telephone contact with collaterals for the purposes of mobilizing services and support, advocating on behalf of a recipient, educating collaterals, and to evaluate and coordinate services specified in the plan;

c. Case management staff time spent on case-specific staffings and formal case consultation with the unit supervisor/other professionals regarding the needs of the recipient;

d. Recordkeeping necessary for case planning, coordination and service monitoring.

4. Discharge Planning

If the recipient enters an inpatient hospital, nursing facility, or ICF-MR, the case management provider may bill for discharge-related case management services up to 30 days prior to discharge from the institutional setting. WMAP discharge-related case management services may not duplicate discharge planning services that the institution normally is expected to provide as part of inpatient services.

E. QUALIFICATION OF CASE MANAGEMENT PROVIDERS

Providers - CM providers must be certified by the Department as meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management services, including:

   a. Comprehensive recipient assessment;

   b. Comprehensive case plan development;

   c. Comprehensive ongoing monitoring and services coordination.

2. Demonstrated CM experience in coordinating and linking such community resources as required by the target population(s);

3. Demonstrated experience with the needs and dysfunctions of the target population(s);

4. A sufficient staff to meet the CM service needs of the target population(s);

5. An administrative capacity to insure quality of services in accordance with State and Federal requirements;

6. A financial management capacity and system that provides documentation of services and costs;

7. Capacity to document and maintain individual case records in accordance with State and Federal requirements.

Qualifications of Personnel: Qualifications for individuals performing case management are divided into two levels: One skill level and proficiency is for individuals performing assessments and case plans, and another is for individuals performing ongoing monitoring and service coordination. It should be noted that many knowledges and skills overlap between the two groups.

Qualifications for individuals performing assessments and case planning are:

1. Knowledge concerning the local service delivery system;

2. Knowledge of the needs and dysfunctions of the target group(s);